

County/Direct Provider Approver Certification

ADP 100177 (Rev 7/06)

For Granting Access to the CalOMS Treatment Data System

ADP ApprovedDate Approver**County or Direct Provider Name:** _____**County or Direct Provider Number:** _____

To ensure the confidentiality of county/direct provider CalOMS Treatment data, the Department of Alcohol and Drug Programs (ADP) requires that each County Alcohol and Drug Program Administrator or Direct Provider Executive Officer designate a primary and a secondary contact to be responsible for approving county/direct provider staff requests for ITWS access to confidential patient data in the CalOMS Treatment data system. Please complete and fax this form to ADP at (916) 323-0653. If you have questions about this form, please call (916) 327-4556 or e-mail CalOMSHelp@adp.state.ca.us.

Primary Approver:**Please print all information**

First Name: _____ Last Name: _____

Title: _____

Phone Number: () _____ Fax Number: () _____

Email Address: _____

Primary Approver's Signature: _____

(Signer acknowledges having read the attached Confidentiality Statement to Users of the Information Technology Web Services (ITWS))

Secondary Approver:

First Name: _____ Last Name: _____

Title: _____

Phone Number: () _____ Fax Number: () _____

Email Address: _____

Secondary Approver's Signature: _____

(Signer acknowledges having read the attached Confidentiality Statement to Users of the Information Technology Web Services (ITWS))

Appointed Vendor(s): (If applicable)

The vendor listed below has the authority to receive, send and process the above-named county/direct provider's confidential CalOMS Treatment information as marked below. The vendor will establish its own primary and secondary approving contacts by completing the Vendor Approver Certification form (ADP 100178).

Vendor Name: _____

Vendor Contact Name: _____ Phone Number: () _____

County ADP Administrator/Direct Provider Executive Officer Certification:

I hereby designate the above-named individuals and vendor, if applicable, to have independent authority to approve ITWS access requests to specific confidential CalOMS Treatment patient data. ADP may rely on approvals, denials, and changes made by the above individuals/vendor in its processing of access requests to this county/direct provider's data in the systems listed above. As changes occur to the above approving contacts or vendor information (name, phone, e-mail), I will complete a new certification and forward it to ADP. Also, I acknowledge reading the attached Confidentiality Statement to Users of the Information Technology Web Services (ITWS).

Administrator/ Executive Officer (signed and printed)_____
Date